Improve Access to Quality Health Care Services

Focus Areas:

6. **Primary Care**
7. **Emergency Services**
8. **Health Care Finances**
9. **Maternal, Infant, and Child Health and Family Planning**
10. **Public Health Infrastructure**

6. PRIMARY CARE

Overview

The District of Columbia Primary Care Office (PCO) was established to administer primary care services. The Health Resources and Services Administration (HRSA) of the Bureau of Primary Care provides funding through the Primary Care Cooperative Agreement. The PCO's goal is to contribute to the development of an integrated delivery system that guarantees seamless access to quality and culturally competent care for residents of all ages, regardless of their ability to pay for services. This goal will be accomplished through:

- identifying gaps in service delivery;
- monitoring disparities in health outcomes;
- developing new primary care training sites;
- monitoring the quality of existing health care services;
- developing placement sites for National Health Service Corps providers; and
- eliminating barriers to the delivery of health care services.

2010 Objectives for the District

Workforce and Site Development

6-1. Increase Access by Increasing Number of National Health Service Corps Loan Replacement Providers

Increase access to care by increasing the number of National Health Service Corps Loan Replacement providers in the District of Columbia from 26 to 36. (Baseline: There were 26 health care providers in the District in 1999. Providers are defined as allopatric and osteopathic physicians, dentists, nurse practitioners, physician assistants, and nurse midwives.)

Program Measure:

- The number of National Health Service Corps placement sites established in Health Professional Shortage Areas (HPSA).

Health Indicator:

- The number of new physician hires in each underserved area.

6-2. Increase Access by Increasing Number of Primary Care Treatment Sites in Underserved Areas

Increase access to care for vulnerable populations in underserved areas by increasing the number of primary care treatment sites from 50 to 60. (Baseline: There were 50 treatment sites in the District in 1999.)

Program Measures:

- The number of requests for Primary Care Certificates of Need applications approved by the State Health Planning and Development Agency.
- The number of National Health Service Corps site development applications approved by HRSA.

Health Indicator:

- The number of new treatment sites established in underserved areas.

6-3. Increase Access by Increasing Number of HPSA Facility Designations

Increase access to care for vulnerable populations by increasing the number of HPSA Facility Designations from two to five. (Baseline: There were two in 1999.)

Program Measure:

- The number of HPSA Facility Designation sites approved by the Bureau of Primary Health Care.

Health Insurance Coverage

6-4. Evaluation of Impact of New Health Insurance Programs

Evaluate the impact of the new health insurance programs implemented in October 1998—Medicaid Managed Care expansion and the Children's Health Insurance Program (CHIP)/DC Healthy Families Program. (Baseline: 10,500 children and their families have been enrolled in DC Healthy Families Program since its implementation in October 1998.)

Program Measures:

- The number of new enrollees in Medicaid Managed Care expansion.
- The number of default assignees among the new enrollees in Medicaid Managed Care expansion.

- The number of new enrollees in DC Healthy Families.
- The number of default assignees among the new enrollees in DC Healthy Families.
- The number of new enrollees in Medicaid Managed Care utilizing health care services.
- The number of new enrollees in DC Healthy Families utilizing health care services.

Health Indicators:

- The percentage of new enrollees per number of those eligible to participate in each new program.
- The results from the mandatory User Satisfaction surveys per contract period for each health insurance program.
- The percentage of new enrollees who have a primary care visit within 90 days of health insurance coverage.

6-5. User Satisfaction with Services of New Insurance Programs

Evaluate patients' satisfaction with the services provided through the new health insurance programs implemented in October 1998—Medicaid Managed Care expansion and the Children's Health Insurance Program (CHIP)/DC Healthy Families Program. (Baseline: Currently there are no collective quantitative benchmark data; the evaluation phases of the programs have not been initiated.)

Program Measure:

- Design multiple survey tools, both qualitative and quantitative, to track patterns in the use of health care services and to evaluate the level of patient satisfaction of all enrollees in Medicaid Managed Care expansion and the Children's Health Insurance Program (CHIP). Surveys include mail-in written, in-person written, telephone, and focus groups.

Health Indicators:

- The percentage of enrollees expressing satisfaction with the level of existing health care services.
- The overall well-being of enrollees as a result of their care received through the new health insurance programs.

6-6. Barriers to Health Care Services

Eliminate existing barriers to receiving primary and necessary health care services by expanding the Managed Care Organization provider roster and by providing information, transportation, and interpreter services for enrollees in the new health insurance programs. (Baseline: Currently, the Department of Health does not have a process to conduct comparative analysis of the services provided by Managed Care Organizations in the District of Columbia.)

Program Measures:

- The effectiveness of educational campaigns promoting enrollment

in Medicaid Managed Care and DC Healthy Families.

- The number of health care providers accepting the enrollee's insurance plan.
- The number of Managed Care Organizations offering customers transportation to primary health care services.
- The number of Managed Care Organization services offering expanded translation services for health program enrollees.

Health Indicator:

- The percentage of new enrollees per number of those eligible to participate in each new program.

Comparable National 2010 Objectives

In the federal HEALTHY PEOPLE 2010 PLAN, under *Goal 1: Improve access to comprehensive, high-quality health care services*, comparable Primary Care 2010 objectives are the following:

1-4 Source of ongoing care;

1-5 Usual primary care provider; and

1-6 Difficulties or delays in obtaining needed health care.

Increase Access to Primary Care — Objective Summary

To realize the outlined objectives in the Plan, an integrated delivery system must be developed guaranteeing access to high quality, culturally competent care for all ages, regardless of customers' ability to pay for services. Guaranteed access to primary and preventive health care services and appropriate utilization of those services are vital to the improvement of the overall health of all District residents, especially those living in communities with the greatest need. Appropriate utilization of primary and preventive health care services is both efficacious and cost-efficient. The inappropriate utilization of hospital emergency departments for ambulatory ailments will diminish once services are accessible and systems are seamless. Improved overall community health leading to fewer visits to hospital emergency departments will ease constraints on a health care system that has been financially overburdened by service misutilization, uncompensated care, and poor health status.

According to 1998 U.S. Census Bureau data, more Americans were going without health insurance. It is estimated that the number of uninsured Americans is now 44.3 million, or 16.3 percent of the population. Most are young adults (18–24 years old), people with lower levels of education, people of Hispanic origin, people who work part time, and immigrants. There is also an increase in the uninsured population in the District of Columbia.

The profile of the uninsured includes single adults and the working poor and their dependents. Factors contributing to this increase are welfare reform, fewer employers offering health insurance coverage to their employees, more expensive health care coverage, ongoing and increased problems with Medicaid enrollment, and an increase in the undocumented immigrant population.

Since October 1998, the District of Columbia has been providing free health care insurance through the State Children's

Health Insurance Program (SCHIP). This program has a benefit package designed for children and their families with incomes at or below 200 percent of federal poverty guidelines. The Medicaid Assistance Administration (MAA) administers the DC Healthy Families Program and is seeking to identify eligible children and their families for enrollment. MAA is looking to further expand coverage through a pilot program to cover 2,400 adults between the ages of 50 and 64 years of age without dependent children and with incomes at or below 50 percent of federal poverty guidelines. Currently, there is a proposal to amend the District of Columbia's Section 1115 waiver application to allow for the expansion.

States around the country are offering SCHIP benefit packages but are learning that outreach to increase SCHIP enrollment is not an easy task. The District of Columbia has projected that approximately 16,000 residents are eligible for the DC Healthy Families Program. Although there have been problems with actual enrollment figures, a variety of approaches are in use to reach eligible residents in the District of Columbia. Some factors that inhibit enrollment in the DC Healthy Families Program include reluctance, as a matter of pride, to accept external assistance for family support, no prior knowledge of the DC Healthy Families Program, a limited understanding of the program, and unfamiliarity with the system.

To boost enrollment, MAA has obtained the services of an outreach broker to help promote program benefits to residents, and of an enrollment broker to act as liaison among the consumers of health services, the MAA, and health care providers. From a community-based social marketing perspective, neighborhood organizations, the faith community, individual residents, and the public and private sectors are actively engaged in these enrollment efforts. Educational campaigns targeting consumers, providers, and employers have been implemented to reach all the people who could benefit from these programs.

In the District of Columbia, the majority of residents are African American. The fastest growing minority group is the Hispanic population. These ethnic groups are most likely to lack insurance coverage, to be underinsured, and to lack an ongoing source of health care. As a result of these populations' sporadic and inconsistent access to health care, there is an enduring disparity between the health status of African Americans and Hispanics, and that of whites. The Asian and Continental-African communities have an increasing presence in the District, and these ethnic groups have their own population-specific health care needs.

Of the District of Columbia's five leading causes of death—in order, heart disease, cancer, cerebrovascular disease, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), and homicide—four can be prevented through early health care intervention, education, and prevention. (Source: State Center for Health Statistics: Vital Statistics Data Sheet, 1997.) These causes of death are consistent with the recorded health status

disparities for African-American and Hispanic populations overall.

These health disparities among racial and ethnic minority populations prove that the health care community is not reaching those who need to be reached. There is an increasing need for health care services to be provided proactively, diversely, and creatively. Sweeping changes must be made in the way the business of health care for traditionally underinsured and uninsured populations is conducted. To reach high-risk or at-risk segments of the population, alterations are needed in the where, what, when, and how of service delivery. Organizations responsible for the management of care for these populations will face challenges and must consider that the patterns of care for the traditionally underinsured and uninsured are markedly different from those segments of the population that have been very well insured.

It is vitally important, then, to have a systematic shift to a safety net system, with consumers, providers, and insurers playing crucial roles. To improve their access, underinsured and uninsured populations need customized services that include translation services, nutritional analysis, psychological and social assessment, transportation, and legal assistance. Health care service delivery needs to be based in the community, with expanded hours of operation and high-quality care that coordinates with traditional safety net providers who are familiar with their community's culture, expectations, and special circumstances related to language or ethnicity. The safety net provider is aware of the challenges and appreciates the diversity of the patient and community. As a caregiver, the traditional safety net provider has coaxed and cajoled patients, provided care with limited resources, been the provider of last resort during off-hours and holidays, and occasionally provided quality care with no payment. Including the traditional safety net provider on the roster of health care service providers will increase consumer satisfaction, enhance medical care plan compliance and behavioral health patterns, and improve the overall health status of District residents.

Responsibility falls on the consumer to make the initial contact, and then to follow up and follow through on a prescribed health care regimen. The newly insured consumer must be receptive to changing old habits and behaviors. People will need to be empowered to reach the level of comfort required to take charge of their health care and medical conditions. Assistance from the organizations responsible for the management of care will be necessary to achieve change. Realizing that some of these newly insured consumers have never had insurance, health management organizations will have to offer education on primary and preventive health care services, recommendations on accessing and utilizing health care systems, and information on consumer rights and responsibilities.

Traditional safety net providers will also need to be reeducated. A fit between the safety net provider and the managed care organization will have to be created to make these new partnerships sustainable and successful. Some safety net providers will require education regarding billing, data systems, data collection, completion of required forms, formulary, enrollment, and scheduling.

Finally, to create change that can be maintained and to shift care from an acute health care setting to a primary and preventive health care setting, collaborations between the public and private sector must initiate state-of-the-art planning and implementation strategies. These strategies should address community-specific health care service needs designed to improve the health status of District residents and to enable them to reach their full potential as productive citizens. In taking these steps, there needs to be an appreciation that change takes time, and the focus must be on long-term change to create access to health care for all and eliminate the disparities that exist for some.

FOCUS AREA: 6. PRIMARY CARE Summary of Healthy People Objectives, Baseline Data, and 2010 Goals		
OBJECTIVE	**BASELINE**	**2010 GOAL**
6-1. Increase access to care by increasing the number of National Health Service Corps Loan Replacement providers in the District of Columbia from 26 to 36.	There were 26 health care providers in the District in 1999. Providers are defined as allopatric and osteopathic physicians, dentists, nurse practitioners, physician assistants, and nurse midwives.	Access to care will be increased by increasing to 36 the number of National Health Service Loan Replacement providers in the District.
6-2. Increase access to care for vulnerable populations in underserved areas by increasing the number of primary care treatment sites from 50 to 60.	There were 50 treatment sites in the District in 1999.	Access to care is increased for vulnerable populations in underserved areas by increasing the number of primary care treatment sites to 60.
6-3. Increase access to care for vulnerable populations by increasing the number of Health Professional Shortage Areas (HPSA) Facility Designations from two to five.	There were two HPSA Facility Designations in 1999.	Access to care for vulnerable populations is increased by increasing the number of HPSA Facility Designations to five.

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FOCUS AREA: 6. PRIMARY CARE *(continued)* Summary of Healthy People Objectives, Baseline Data, and 2010 Goals		
OBJECTIVE	**BASELINE**	**2010 GOAL**
6-4. Evaluate the impact of the new health insurance programs implemented in October 1998 — Medicaid Managed Care expansion and the Children's Health Insurance Programs (CHIP)/DC Healthy Families Program.	10,500 children and their families have been enrolled in the DC Healthy Families Program since its implementation in October 1998.	The impact of the new health insurance programs implemented in October 1998 will be evaluated.
6-5. Evaluate patients' satisfaction with the services provided through the new health insurance programs implemented in October 1998—Medicaid Managed Care expansion and the Children's Health Insurance Program (CHIP) /DC Healthy Families Program.	Currently there are no collective, quantitative benchmark data; the evaluation phases of the programs have not been initiated.	Patients' satisfaction with the services provided through the new health insurance programs implemented in October 1998 will be evaluated.
6-6. Eliminate existing barriers to receiving primary and necessary health care services by expanding the Managed Care Organization provider roster and by providing information, transportation, and interpreter services for enrollees in the new health insurance programs.	Currently, the Department of Health (DOH) does not have a process to conduct a comparative analysis of the services provided by Managed Care Organizations in the District.	Existing barriers to receiving primary and necessary health care services will be eliminated by expanding the Managed Care Organization roster and by providing information, transportation, and interpreter services for enrollees in the new health insurance programs.